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VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

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MR. WELLS: My name is Jim Wells. I'm the Chair of the Regulatory Research Committee. This is a public hearing to receive public comment on the board's review of the feasibility of licensure of certified anesthesiologist assistants.

The Code of Virginia authorizes the Board of Health Professions to advise the governor, the General Assembly and the department director of matters related to regulation of health care or occupations and professions.

Accordingly, the board is conducting this review and will provide recommendations on the feasibility of licensure of certified anesthesiologist assistants.

We have a list of folks who have signed up. We want everyone to have a chance to make a comment. We will go through the list. You are free to speak a second time, but we would ask that you wait until everyone has had their turn and we will ask questions if you don't mind.

If you are not ready for a question, we can certainly understand that. But we would, if possible, like to be able to ask a question of the speaker if you don't mind.

DR. CARTER: In the event of a fire or

other emergency requiring evacuation of the building, an alarm will sound. When the alarm sounds, leave the room immediately. Follow any instruction given by security staff. For exiting this room you may use this door or the door right behind you and make a right. You would go across the parking lot and meet at the fence. Basically just follow the staff to make sure you get out.

Thank you.

MR. WELLS: At this time I will call the persons who have signed up for comment. As I call your name, please come forward and tell us your name and who you represent and what region or area you're from please.

The first person is Katie Payne.

MS. PAYNE: Good morning. I'm Katie Payne. I work at Williams & Mullin and I represent the Virginia Society of Anesthesiologists. I'm from the Richmond area.

I've been to all of your meetings. So you've heard a lot from me already. But thank you for having us and having this public comment hearing today. We have been looking forward to it.

You all know from my past appearances before you that the Virginia Society of

Anesthesiologists represents about 900 physician anesthesiologists in the Commonwealth. We have been working for years on licensure of CAAs. We have been studying it and watching with interest as other states around us have adopted licensure really across the country, and we have seen great results.

Our membership is overwhelming supporative of licensure CAAs in Virginia. We have quite a crowd here today, as you can see, and not everyone will have a chance to speak. We have tried to narrow our comments and keep them to the seven criteria that you all are considering.

But, if you don't mind, I would ask for everyone who is supportive of CAA licensure to stand briefly.

Thank you.

I'm sure you guys realize, it's the same for you, they all had to take off days from work, from school and for most of them drive a fairly long distance from the D.C. area to get here. So we are very appreciative of their support.

Within that group we have members of the Virginia Society Anesthesiologists, the American Society of Anesthesiologists, the quad A, which is the American Academy for Anesthesiologists

Assistants, the VAAA, which is the Virginia Academy of Anesthesiologists Assistants, which is made up of Virginia residents, who are licensed as CAAs but have to leave the state to work. You will hear from some of them today.

We also have a couple of physician anesthesiologists who work closely with CAAs. So you can hear their perspective. And then we have some CAA students from the D.C. area. So you will hear from all of them today.

As I said earlier, we are trying to be respectful of your time. We have 10 people or so lined up to speak, and we will go through the criteria one by one as was requested at the last meeting.

But, again, we are a resource for you. Please, as you said, interrupt us with questions and we would love to follow up with the end to any outstanding issues.

Thank you very much for having us.

MR. WELLS: I apologize in advance if I misspeak anyone's names and that is why we ask you to restate it.

Layne Diloreto.

MS. DILORETO: My name is Layne Diloreto

and I am here to represent the Virginia Academy of Anesthesiologist Assistiants.

Good morning members of the Virginia Board of Health Professions. My name is Layne Diloreto and I'm a certified anesthesiologist assistant or CAA. I began practicing as a CAA in 2009, and I've been living in Virginia and working in D.C. since 2011. Last year my husband and I bought our first home in Alexandria, Virginia. And I would love to be able to continue to work as a CAA without having to cross state lines.

Criteria One addresses the risk for harm to the consumer. I would first like to address the educational requirements to apply to anesthesiologist assistants schools. All of the candidates must possess an undergraduate degree. Just like those preparing for medical school, candidates can graduate with any major as long as they fulfill the course requirements.

These include an English course, General Biology, General Chemistry, Human Anatomy and Physiology, Organic Chemistry, Biochemistry, General Physics, Calculus and Advanced Statistics. These course requirements are identical to the majority of medical school prerequisites.

Additionally, candidates must submit scores from a standardized test, either the impact or the GRE. All anesthesiologist assistant programs are graduate schools with dyadic and clinical requirements.

Physically it's 56 to 132 hours of dyadic training, as well as an average of 2,500 clinical hours over the course of 24 to 28 months.

CAAs only practice under the medical direction of a physician anesthesiologist as part of the anesthesiologist care team model.

In comparison, nurse anesthetists work under a physician anesthesiologist or another speciality profession such as a surgeon, pediatrist or dentist. Nurse Anesthetists do not practice independently in the State of Virginia.

Working under the supervision of a physician anesthesiologists in the anesthesia care team model directly correlates with quality of care especially in times of emergencies. Most physicians do not routinely provide airway management and do not have the extensive training that physician anesthesiologists have in diagnosing and treating acute perioperative events.

When a CAA encounters a problem while

working under a physician anesthesiologist, you have two individuals highly trained in anaesthesia instead of one. They share anesthesia knowledge and training within the care team model provides for the absolute best and safest care for patients.

I currently work at a surgery center in Washington D.C. Our facility uses the care team model. Everyday I work collaboratively with physician anesthesiologists, CAAs and nurse anesthetists. Our CAAs and nurse anesthetists are interchangeable and we are supervised in an identical matter. As anesthesia providers who have a proven track record of being safe and confident, I respectfully request that this Board supports the licensing of CAAs in Virginia.

Thank you for your time.

DR. CARTER: I do have a question.

When you say that you are supervised directly, does that mean the anesthesiologist is in the building?

MS. DILORETO: Yes.

DR. CARTER: So you do not take independent calls?

MS. DILORETO: Correct.

DR. CARTER: Thank you.

MR. WELLS: Next is Jeremy Betts.

MR. BETTS: Good morning members of the board. My name is Jeremy Betts. I'm the director of State Affairs or The American Academy Of Anesthesiologist Assistants and I'm from Atlanta, Georgia.

CAAs were developed in the late 60's by a group of physicians due to an anesthesiologist or anesthesia provider shortage across the nation. The first program was established at Emory University in 1969 and Case Western Reserve in Ohio following shortly thereafter.

The CAAs are governed by the National Commission For Certification Of Anesthesiologist Assistants, which requires three ongoing aspects of licensure. First, an initial certified exam, ongoing registration and continuing medical education and then approximately every six years recertification for examination is required of every CAA. Currently 17 jurisdictions with the addition of (inaudible) utilize CAAs either through licensure of declaratory authority. Virginia is surrounded by North Carolina, Washington, D.C. Kentucky, Ohio, all of which would utilize CAAs.

In 2006, the Veteran's Administration

classifies anesthesiologist assistants as a provider within the VA system as well as TRICARE recognizes anesthesiologist assistants as a recognized provider for anesthesia services.

Furthermore, CMS recognizes anesthesiologist assistants as anesthetists along with nurse anesthetists in regard to Medicare and Medicaid payments whereas anesthesia services. Commercial insurance payers do not treat the medically directive services for anesthesia any differently if rendered by a nurse anesthetist or an anesthesiologist assistant.

In a recent survey study that was provided from Stanford University -- I believe that the study was delivered to you -- the researchers were able to take a look at retrospective medicare fees for services, where patients who received inpatient care from an AA or a NA, and that is for 2004 through 2011. The study size consists of roughly 450,000 cases.

Looking at inpatient mortality and patient length of stay and inpatient spending, the study concluded that AA care was not associated with -- statistically significant difference in patient mortality, length of stay or spending compared to NA

care.

Increasing the number of states for CAAs can practice is likely to be associated with a decrease in patient safety or care in following along with the study. Additionally as Layne just spoke to the anesthesia care team provides a greater level of safety for each patient with an advanced practice provider as well as a physician anesthesiologist immediately available. I can speak to that.

There are three different levels immediately available provided throughout the regulatory constracts through the nation, the least restricted being under CMS regulations, which requires immediately available somewhere within the physical proximity and then varying constracts all the way up to within the surgical suite or the set of rooms to which a surgery will be taken care of. So a physician is always available within a physical proximity to the anesthesiologists assistant.

Lastly, the CAAs scheduled practice is determined by four things; any applicable statute or regulation by the state, the state's board of medicine or licensing authority, the credentialing authority at the hospital, and then lastly, and

arguably most important, the physician, who delegates the authority to that anesthesiologist assistant to practice and ultimately has control of the anesthesiologist assistant.

I'm happy to stand for any questions if there are any. And thank you for your time.

MS. HAYNES: A physician or does it have to be an anesthesiologist specifically?

MR. BETTS: And an anesthesiologist assistant, an anesthesiologist.

MS. HAYNES: Thank you.

MR. BETTS: Thank you.

MR. WELLS: Shane Angus.

MR. ANGUS: Good morning. My name is Shane Angus. I'm a Certified Anesthesiologist in Washington, D.C. where I practice as a Certified Anesthesiologist. I'm also the program director for the Case Western Missouri University. I am here today to speak to you about Criteria Two, which is the specialized skills and training.

First, I would like to recognize some of the students who made the trip down here today. One thing that I found that is important as an educator is to make sure they appreciate the rules and regulations that are directed and practiced. And if

it's okay with you, I would like to recognize them. Many of these students are Virginians and they would love to come back and work and be citizens of Virginia.

Specifically regarding their education, there are several rigorous steps that must be taken into the program. Mainly, they must enter into a program that has a curriculum that results in a degree, a master's, but is run through a school of medicine. They must also house a program within the anesthesiology department that has the educational facilities to house an anesthesia residency program.

In addition, there is a program with specific accreditation CAAHEP, Commission on Accreditation of Allied Health Education Programs, by which there are 27 different professions under that umbrella.

There is also a requirement that the instructors, in which the anesthesia students learn from, has to be a physician anesthesiologist, certified anesthesiologist assistant, as well as any other health care professional whose ground is relevant to the practice of anesthesia.

There are numerous programs that have met the benchmark for meeting all of these criteria and

they are at Emory University, Case Western Reserve University in Washington D.C, Cleveland, Ohio and Houston, Texas. There is also Emory University in Atlanta, Nova Southeastern, which is in Fort Lauderdale and Tampa. There is a University of Colorado in Denver, Indiana University in Indianapolis, Connecticut, and Medical College of Wisconsin, Milwaukee.

So after they have obtained these programs and they are nearing graduation, they will sit for their initial examination, which is assessed through the National Certification Commission for Anesthesiologist Assistants, which is administered through the National Board of Medical Examiners.

After they have completed that examination, they will then be allowed to obtain of themselves as a Certified Anesthesiologist and every two years they will need to demonstrate continuing medical education of 40 hours. And every six years they will have the pleasure of retaking that examination to maintain their certification and that will be ongoing.

For these reasons and numerous others, the demonstrations, I believe, is hopefully fulfilled in your eyes to that criteria number two.

Thank you very much.

DR. CARTER: I just have one question.

The examinations, you said they are retaking it or is it a recertification exam, a separate exam from what the original was?

MR. ANGUS: Correct. There is an initial examination, year one. And then there is a recertification in every six years.

DR. CARTER: Thank you.

MR. WELLS: You mentioned a master's, what's the actual degree?

MR. ANGUS: Degrees in master's degree which is determined by the institution, the title of that master's. So certain institutions may call it a master of science and anesthesia and another institution may call it a master's of science -- medical science.

MR. WELLS: Approximately how many hours? I think in terms of four years, two years.

MR. ANGUS: Very good. Thank you. There are different agencies which credit the different regional institutions and it gives them a lot of flexibility to determine how many hours a credit hour means. So the hours vary quite a bit. They are all master's degree. The minimum is 24 months

and the maximum is 28 months.

Thank you for your time.

MR. WELLS: Rose Wilson.

MS. WILSON: Good morning. My name is Rose Wilson. I'm the president of the Virginia Academy of Anesthesiologist Assistants. I'm a Certified Anesthesiologist Assistant living in Alexandria, Virginia but working in Washington, D.C.

My family moved to Northern Virginia in 2001. And while I left the area to attend the CAA program, I always knew I wanted to come back to Virginia to practice and live. I have been working as a CAA in D.C. since 2012. I purchased a home in Alexandria, Virginia in 2014. Being able to work in Virginia would greatly enhance the life that I have built here.

I want to recognize the other CAAs here today, who would also like to have the opportunity to work in Virginia and to contribute to our local community. There are currently 14 CAAs that are residents of Virginia but must travel to North Carolina or D.C. for work.

Additionally, the current class of CAA students from Case Western Reserve University in Washington, D.C. are present. Eight of these

students are Virginia residents and many others want to stay in the area after graduation. Students have the opportunity to rotate and train in Virginia with Dr. Laser (phonetically) at August Health in Fishersville, Virginia or with any anesthesiologist willing to supervise on a one-by-one basis.

Unfortunately, after the training is complete, they must leave the state to practice. By having licensure available to CAAs, Virginia would retain these students and attract additional highly trained educated professionals to the area.

Criteria three discusses autonomous practice. Certified anesthesiologist assistants are autonomously functioning deep in their practitioners who work exclusively within the anesthesiology care team model under the direction of a physician anesthesiologist.

The license of the CAA allows for a wide range of functions including, but not limited to, performing a thorough pre-anesthetic history and physical, formulating an anesthetic plan, obtaining necessary diagnosis studies and blood work, determining the need for invasive and non-invasive monitors such as arterial lines, central lines and placing and managing regional anesthetics, spinal,

epidural, interpreting monitors while initiating treatments and adjusting the anesthetics.

In additional to our daily patient care responsibilities, we are also an integral part of managing emergencies, including difficult airways, advanced cardiac life support, and pediatric advance life support. We contribute to the departmental and institutional development as members of the community to improve patient safety outcomes and to reduce surgical site infection.

CAAs provide safe and effective patient care in all surgical specialties including, but not limited to, cardiac, trauma, pediatrics, obstetrics and gynecology, orthopedics, vascular and plastics.

We currently work in all types of institutions ranging from ambulatory surgery facilities to level-one trauma centers such as Children's National Medical Center in D.C., Brady Hospital in Atlanta, Metro Health Medical Center in Cleveland and Dallas Children's Hospital.

I hope to soon add the excellent facilities in Virginia to this list. The CAA profession is growing and the residents of Virginia would greatly benefit from the care that CAAs can provide.

Thank you for taking the time to consider a

licensure of Certified Anesthetist Assistants in Virginia.

MR. WELLS: Dr. Matthew Pinegar.

DR. PINEGAR: My compliments to you on pronouncing my name correctly. Most people don't get it right the first time.

I'm Dr. Matthew Pinegar. I'm a physician and anesthesiologist and I practice in Washington, D.C. at the Washington Hospital Center. I'm a transplant to the state of Virginia. I lived in McClain, Virginia in Fairfax County for the past eight years when I accepted a job in Washington, D.C. and moved to the area.

Among my roles and my responsibilities at Washington Hospital Center, in addition to the clinical practice that I take part in, I also function as the medical director of the assessment clinic that we have at our hospital. I also participate as the medical director of the Case Western Reserve University, master's in the science and anesthesia program that we have at the Washington Hospital Center as well in Washington, D.C.

I would like to talk a little about the scope of the practice. Now according to federal

regulations, anesthesia must be administered by a physician anesthesiologist, by a MD or DO physician graduated from a school of medicine or it must be administered by an oral surgeon, a pediatrist or a dentist who is qualified to administer anesthesia.

In addition, anesthesia can be administered by a certified registered nurse anesthetist or by an anesthesiologist assistant, both of which are defined as anesthetist under federal regulation as well.

I think the most important thing I can share with you is a little bit about how we practice at the Washington Hospital Center and how we utilize both nurse anesthetists and anesthesiologist assistants in our practice. We follow the anesthesia care team model -- which are covered by an anesthesiologist and may involve AAs and CRNAs as well. At our hospital we have 32 NCRAs and 42 AAs. Our AAs have increased dramatically from the handful of AAs that we had when I started as an anesthesiologist at the hospital.

At our hospital we are involved in the training of residents, anesthesia positions, student nurse anesthetists, who are in the Georgetown program as well as the anesthesiologist assistant

students that we have from Case Western Reserve University. The way we utilize our anesthesiologist assistants and our nurse anesthetists are identical. We do not distinguish between the two. The scope of practice and the activities in which they are engaged are identical. It is my opinion that the outcomes between the AAs and the CRNAs in their practice are identical as well.

They are in every aspect of our anesthesia delivery whether it be in the operating room, in the pre-assessment clinic or the assessments after anesthesia delivery on the floor or in the recovery room.

I would like to speak to the training that we provide to both our student nurse anesthetists and our anesthesiologist assisting students. As an example, my day yesterday started out with clinical involvement in a case involving an anesthesiologist assistant student. Later in the day I was assigned to a different case where I had involvement with a student nurse anesthetist. And the type of clinical training that I gave both students was identical.

The two cases were very similar cases and the expectation that I had for both students was virtually unchanged. Following graduation the

things that we expect of our AAs and our CRNAs, they are the same, when it comes to giving breaks or relieving, AAs and CRNAs who reach the end of their shift, we interchange the same. And we do not make the distinction between who can leave or who assumes the care of a case based on their licensure or the type of training that they have done.

While I will admit that certain individuals show that they have an increased ability, increased skill, increased knowledge compared to their peers, it is not based at all upon the training program that they had attended, but more on their individual work ethic or the type of training that they focused on.

I will maintain that no one is a complete or perfect anesthetist, that everyone focuses on different areas. So certain individuals may have particular expertise in certain areas. While being capable of doing regional anesthesia, for example, there are other people in my practice that focus on it more. And you will find that certain AAs and CRNAs will gravitate to certain areas and will have particular expertise in certain areas. But as a whole and as a group there is no difference in our expectations for AAs and CRNAs. There's no

difference in outcome.

It's interesting that in last month, in May, at the annual meeting of the Association of the University of Anesthesiologists in Washington, D.C. there was a study that was presented which took in account over 452,000 cases that were billed under the Medicare service that demonstrated that there was no significant difference in outcome whether an AA or a CRNA was involved in the case.

Do you have any questions for me?

MR. WELLS: I do. In talking about the care team model, do your AAs induce?

DR. PINEGAR: They participate in the induction. The policy in our hospital is that every anesthetist is supervised by a physician anesthesiologist. And it's the policy and practice at our hospital that all inductions take place with the physician anesthesiologist present whether a nurse anesthetist or an anesthesiologist assistant or a student is involved in the case.

MR. WELLS: Same question for the initiation of a spinal, a regional.

DR. PINEGAR: There are times when our nurse anesthetists or AAs will initiate regional anesthesia, particularly the nerve blocks without

the actual presence of the physicians. Up in labor and delivery, sometimes things can get pretty busy. So, occasionally, we will be supervising multiple sites at the same time.

So, while we do make it a practice -- or at least certainly I do, of seeing every patient before initiation of any anesthetic, there are times when the anesthesiologist will not be present for every --

MR. WELLS: Do they attend codes?

DR. PINEGAR: Codes, like a code blue, yes. They will help out in emergency situations if they are available and they are the first to respond, then they will help there.

MR. WELLS: Dr. Scott Frank.

DR. FRANK: Good morning. My name is Dr. Scott Frank. I did my medical training up in Buffalo, New York, where I'm originally from and then I trained in surgery in Pittsburg, and then did training for anesthesia back up in Buffalo, did undergraduate training or undergraduate education at Georgetown University.

So when I was looking for a job I decided to come to the D.C. area. And at the time in Virginia in 2005 when I was coming here, there was

no real jobs for my criteria in Virginia. But I did take a job at the Washington Hospital Center, where I have been working for the last 12 years. And I am licensed in the State of Virginia as a physician and I'm also a member of the SADCHA. I have not joined the Virginia Society as of yet. But I was looking a couple of years ago to practice in Virginia, but because I was promoted to the medical director of the OR Operations at the Hospital Center, I decided to stay there for a little while longer.

My position at the Hospital Center is I'm an attending physician anesthesiologist doing fulltime clinical. I'm also, as I said, an OR Operations Director, Medical Director. I'm also Associate Director of Obstetric Anesthesia. I'm an anesthesiologist in the specialty as well, obstetric, and also trauma surgery as well.

I have for the last 12 years, almost 13 years now, in the Hospital Center and directly with the AAs, certified AAs. I might repeat some of the things Dr. Pinegar said since he's my colleague. We work together. I agree with him. I say that I feel that there is no difference in the practice of the certified anesthetists when I work with them compared to the CRNAs. They are a very good group

of individuals that we have at our hospital. They are very talented.

I would add to his comments, in the sense that in our hospital, we deal with a very, very high risk population of patients, very sick patients. And that is something that we require, particularly when we train the anesthetists as well, both from the Georgetown students, CRNAs as well as students from the AA programs -- when we select them, potentially to hire them afterward, we do kind of have our pick of the litter also in the sense of -- it's usually a hard choice, I will say that because all of the training programs do a very good job of educating these individuals. And having had them train at that institution actually what makes a big advantage to that career because they are exposed to such a level of care, that is one of the things that makes them allow to work anywhere in the country after that training there.

I actually came to that Hospital Center like that to start with because I felt it would really promote my clinical skills and I feel like it has in that regard dramatically.

So, with that said, the students I teach as well, as they mentioned about their training

programs, the students do a very good job. They go through the same kind of premedical education that I went through in a sense. And, therefore, they seem to have kind of a good approach to medical management in that regard because of having that background. I find that it works well on both sides. The nurse anesthetists, the CRNAs I work with, they meet each other. They give each other breaks. They are a very good quality group that we have at our hospital. And as I said before, I really notice no major difference between the two.

A couple of other points, CMS requirements basically for medical direction basically is limited to no more than four anesthetists. That doesn't mean we get four for each anesthetist. For each additional case that we cover or supervise, medical direct, we actually get paid less and less, so it's not that we get paid the full amount for that. So it is an advantage, I think, to the care team model in that regard that potentially reducing cost but that is once again -- that's just a point about the care team model as well.

There is basically no difference in compensation for, I believe, insurance or CNS as well. CRNAs and AAs get pretty much paid the same

for the most part or for insurance reimbursement to the hospital.

I would note as well that we have actually advanced -- in practicing obstetrics, it's usually a lot of institutions particularly a low risk environment for obstetrics -- it's common practice to just have anesthesiologists covering those. But because we have a high risk obstetrics department, we have actually advanced to a care team model where we have an anesthetist on 24/7 as well with us.

And the reason for that is because the environment is so difficult sometimes with very difficult sick moms who come in with babies and sick babies that come in that we really do need to take advantage of the extra hands as Dr. Pinegar was saying.

They are allowed to go and start C-sections on their on, both the AAs and the CRNAs as well. We are always on the floor in that regard. And we can always back them up in that regard. But they do have a lot of leverage in that regard when it comes to obstetrics in particular.

We are always present starting every single case for CRNAs and AAs. We are always in the room. They can push drugs if you would like to induce

patients. I think that was your question. They can push drugs. But we are always in the room for airway management support and to get cases started in that regard.

Are there any questions or comments?

DR. ALLISON-BRYAN: It really sounds like they are pretty well supervised at the Washington Hospital Center.

DR. FRANK: Yes.

DR. ALLISON-BRYAN: Do you have any idea how your model, anesthesia care team model, compares to other hospitals that are using CAAs -- I mean, is this a --

DR. FRANK: I think other institutions -- I mean, our institution, we deal with one of the sickest patient population in the country. So with that data, I think it's very easy to do if you were to go to a community center hospital versus another big center like over in Fairfax, which is near me, Fairfax Hospital Center, I think there would really be no difference. I don't think I would have any concerns about where they trained in the sense. With anything in anesthesia particularly, a lot of it has to do with their experience level.

So most of the training programs that we

have, the students we have, they seek out, but also the same thing with the certified nurse anesthetists, they seek out different opportunities to gain the experience.

And as Dr. Pinegar said, they will kind of fan out into some areas where they like to specialize. We have some anesthetists who only do obstetrics. And we have some anesthetists who prefer not to do certain types of cases. But that is their personal preference. And that is actually the same thing that happens in the anesthesia profession as well. So we kind of have specialities, the things that we kind of like to do. It's just a common practice.

MR. WELLS: Jason Hansen.

MR. HANSEN: Hello. My name is Jason Hansen. I serve as the Director of State Affairs for the American Society of Anesthesiologists. I'm a resident of the State of Virginia. My wife and I own a home in Alexandria.

The American Society of Anesthesiologists supports licensure of CAAs in all states. They are valued members of the anesthesia care team. The anesthesia care team provides an anesthesia person performed by or supervised by a physician

anesthesiologist constitutes the practice of medicine.

Certain aspects of anesthesia care can be delegated to other properly trained and qualified individuals. These professionals, medically directed by physician anesthetists, constitutes the anesthesia care team. While selected task delegated to these qualified individuals, responsibility remains with the physician anesthesiologist. The physician anesthesiologist determines which tasks are delegated or participates in critical components of the anesthesias and remains physically available for management of emergencies regardless of the type of anesthetic.

State authorization of certified anesthesiologists assistant licensure has been ongoing. Seventeen jurisdictions now authorize CAA practice. This established profession has been serving patients for over four decades. We in the Department of State Affairs are seeing more and more states across the nation seeking to add CAAs to the range of their licensed professionals.

As someone who has personally received anesthesia care from a certified anesthesiologist assistant practicing within the anesthesia care

team, I strongly support their licensure in my state and hope not to have to leave Virginia again to receive this care.

Thank you.

MR. WELLS: Danny Mosaros.

MR. MOSAROS: Good morning. My name is Danny Mosaros. I am a practicing certified anesthesiologist assistant in Washington, D.C. and a Fairfax County Virginia resident. I am the director of dyadic construction (phonetically) at Case Western Reserve AA Program and I also serve on the board of directors for the American Academy of Anesthesiologist Assistants. I would like to thank the Board for allowing us to speak today.

I will be speaking to criteria five, which is the economic impact, the licensure of CAAs in Virginia. Certified anesthesiologist assistants are recognized by the CMS, which is the Center of Medicaid and Medicare, of all commercial insurance -- CMS recognizes the anesthesiologist assistants as qualified non-physician anesthesia providers. Insurance payers do not distinguish between certified anesthesiologist assistants or nurse anesthetists in regards to services rendered under the anesthesia care team model.

Currently anesthesiologists are the only physicians in the Commonwealth with one option for a physician extender. This is problematic because it limits their choice of provider and their ability to incorporate the anesthesia care team.

Licensing or certified anesthesiologist assistants will eliminate this issue and ensure physician anesthesiologist involvement with every anesthesia provided. This model of the care team is proven and is the optimal approach for providing safe and cost effective care.

The addition of competition in a supply and demand market is beneficial for the consumer. Data provided by the Bureau Of Labor And Statistics further supports this statement.

In states where anesthesiologist assistants have created a competitive job market there is a 15.2 percent increase in the average salary because anesthesia providers in the care team model are compensated equally in the care team model. This decrease in average salary is due to competition.

The licensing of anesthesiologist assistants will help decrease in the anesthesia related health care cost while meeting the increase and demand for anesthesia providers in Virginia.

Finally, I would like to address the cost associated with licensing and regulation of a new profession. The licensing will certify that anesthesiologist assistants will fall in line with this strategic plan put forth by the Department of Health Professionals.

Our experience with other states have found this process to be budget -- considering the number of AAs that already reside in Virginia, the proximity of an AA program can meet the immediate demand and the addition of a new AA program in Virginia. This will ultimately result in a contributing factor to the Department of Health Professionals revenue.

Thank you very much for your time.

MR. WELLS: Dr. Engels.

DR. ENGELS: Good morning. My name is Dr. Emil Engels. I'm a physician anesthesiologist and the president of the Virginia Society of Anesthesiologists. I have lived in Virginia most of my life. I grew up in Northern Virginia. I graduated from West Springfield High School. I went to the University of Virginia for college. I left for a few years and then came back in 1999 to work at Fairfax Hospital. I have been there ever since.

Our practice is quite large. You heard Dr. Frank talk about it. My own practice, I employ 70 physicians and 100 CRNAs. Our practice is part of a national company, which employs over 3,000 anesthesia providers, 1,500 physicians and over 1,900 anesthetists including both CRNAs and CAAs.

I'm going to address criterias six and seven. But before I get into that I did want to return to your question, Dr. Bryan, about how CAAs have been covered in other locations. And I agree with Dr. Frank; they are required to be supervised by a physician anesthesiologist and we would cover anybody in a similar matter.

Criteria six as for alternatives to regulation, there really is none for CAAs to practice in Virginia. We feel strongly that licensure by the Board of Medicine protects the public interest and ensures practitioner competency. And really is essential and is in the best interest of the public to have CAAs licensed in Virginia.

I also wanted to comment that as president of the VSA, we are as a society and as individuals, we are very supportive of CRNAs. This is not directly to CRNAs, but rather designed and we are advocating on behalf of this to create a choice of

providers we hire and to get any other pool of qualified providers to hire from in Virginia. This information was provided to you earlier by Ms. Payne.

But it shows you the number of licensed care extenders for each physician class in Virginia. On average, physicians have access to 6.5 different extenders. As anesthesiologist have access to one and that is CRNAs. So it's really about having choice, another pool of qualified providers to hire from.

To give you examples, I mentioned we are part of a large company, Midnex (phonetically). Our company alone has 40 unfilled CRNA positions in Northern Virginia. So we have 40 jobs available for CRNAs that we can't fill right now. The way we are staffing is by paying overtime to our current providers, -- but, clearly, that is not a good long-term solution.

I would also make the point that we have data from MPI, which shows that when CAAs enters a marketplace in a particular state, they don't displace nurse anesthetists and student nurse anesthetists.

In fact, in states that CAAs have come into

those numbers have increased. There has been growth in nurse anesthetists numbers in states where CAAs have been introduced.

I conclude by talking about this section, criteria six. Our company nationally employs CAAs in other states. We have 40 openings at the moment for CAA positions. And we would hire CAAs as soon as that was permissible by state law. So we are in the position where we would actively hire CAAs.

Criteria seven talks about the least restrictive regulation that is possible. Of course, CAAs would need to be licensed in the state of practice here, but we are in favor of creating statutory language that is differential as appropriate allowing the Board of Medicine to really govern that process. CAAs are licensed with the Board of Medicine in different states.

And, finally, I would like to point out that there are CAA schools from around the country that has shown interest in expanding in Virginia. We have received interest from Case Western, Nova Southeastern. These are schools that are actively pursuing opportunities to start CAA programs in the State of Virginia.

Thank you very much. I would like to say

again that the VSA is very supportive in licensing CAAs in Virginia. Thank you for your time. I'm available to answer any questions. Thank you.

MR. WELLS: Brian Ball.

MR. BALL: Thank you. I'm last for our group. I'm Brian Ball. I practice law at Williams Mullen here in Richmond. I've represented the Virginia Society of Anesthesiologists, as you can see from looking at me, for decades now. I am very proud to be here. They are a group of bright and young, energetic people who want to practice their profession in our state and it's really an honor to be a part of this initiative.

I don't know if it was mentioned earlier, but there are 12 CAA schools in the country. Virginia would like to have one of them as well. There is a great interest in doing that. So competition for Mr. Angus and Case Western and some of the other schools that were mentioned today.

We have a lot of veterans in the State of Virginia. It creates for somebody coming out of the military, it's a great career track to go into the master's program once the individual has completed the necessary prerequisites.

We derive great comfort from the studies

that you heard through the doctors mentioning in terms of the outcomes, the quality of care. The outcome is the best, I think, mentioned by Dr. Frank.

There was a question, I believe from you, Dr. Allison-Bryan, about the model in other jurisdictions or other hospitals. I did have a handout that, if I could approach, I would like to give you in places where CAAs practice at this point. It represents where they practice nationally. And it's a pretty good looking list.

MR. WELLS: I have a question and it's a general question, and I hope it doesn't seem like it's derogatory or anything like that. I don't see here any facilities that are below 250 beds. Any CAAs out there that can work in a facility less than 200 beds?

UNIDENTIFIED SPEAKER: In the District of Columbia we practice, obviously, at Washington Hospital Center, but we also practice at providence Hospital, which is a small catholic run hospital. It's about 10 ORs.

MR. BALL: I can assure you that these young people if they can practice their profession in smaller hospitals, there is no diversion for them

to be anywhere they can be gainfully employed and challenged. So, I don't think that is an issue.

And this is a really good list of hospitals. And I haven't thought about the smaller ones, but it's an impressive list of hospitals. It just demonstrates the level of comfort once the CAAs can practice in these facilities -- that the facility has with the anesthesia care team that includes the CAAs.

And a question was asked about code blue. We have some very modest people in the room. But two weeks ago we had the mess up in Alexandria with the members of Congress. People were injured. And Dr. Frank, who spoke earlier, was the anesthesiologist on deck, and a very quiet and modest CAA, Katelyn Dyburan (phonetically) sitting back here was the CAA in the OR. The doctor and CAA did what they have to do to take care of some people that were injured. So there is no difference. There is no difference. That's the point of that.

That concludes our presentation. We have all of us here to answer any questions any of you may have. And we thank you for letting us come visit with you today.

DR. CARTER: Since you have concluded your

presentation, I would like to go back and ask Mr. Angus a question. And I think out of all the people I've heard, you might be the best person to answer this.

From what I read about CAAs, they were developed by anesthesiologists and it sounded like in the back of their mind they were thinking that some of these folks might want to go on to medical school.

So my question is actually the reverse of that. The premedical training that the CAA students gets is identical to the premedical training that I got. How many of them didn't get into medical school, so they are applying to the CAA program?

MR. ANGUS: That's a great question and quite fundamental on a number of regards to be quite frank with you. The idea, you have a point there. There was a shortage and maybe we can start intriguing these young people to come into the anesthesia field, so, back in the 60s and 70s. So numerous individuals did that. They basically went though and got their master's and then went ahead and got their physician's degree and trained -- as time has gone by, as the health care climate that we are currently living in has continually changed in

many directions you can say, the people who have been applying to our program -- there has always been an interest in going to medical school and are looking at this and thinking is there something else.

So a huge portion of these applicants are individuals who are stepping away from going to medical school and they have the pedigree. They have the MCAT score. They have the GPA. So without question it would get them into a very strong medical school.

So about a third of my students are just that. Another third are individuals who are on the bubble, right. They might be able to get to the furthest program from their home and go to medical school -- maybe they could go to one of the Caribbean schools and looking at what else is out there, what other options are available to me.

So my thought is here are these groups of people who are clearly bright. And by the chances of an examination their scores are two or three points below the average and they are not being accepted, yet what are we doing with them as a society. Are we just going to say well, sorry pal. We'll see you later. Enjoy what else you are going

to do. Well, I think these are great candidates for people who would be excellent in their profession.

So about a third of the students would have just that. There are people who looked at other options and said this might be a good one. So those are the two groups that would fall into that.

DR CARTER: So, in general, if you look at your application versus acceptances over the past couple of years, because given what you told us you probably have access to that information.

MR. ANGUS: Yes.

DR. CARTER: What does it look like? How selective is it?

MR. ANGUS: Quite selective. We are looking at a group of people -- this is a brief story. So I went to recruitment at Johns Hopkins. And I was at Johns Hopkins and there was a lot of other medical schools there. I was talking to the chair -- the commission who takes care of this event and he was looking at our criteria. And he kind of chuckled and said why would anybody go to your program. You have more requirements than an average school. So there are additional requirements that we mandate. So, it can be hard, yes.

DR. CARTER: So, of your applications, for

every two applications, are you accepting one, I mean just in general?

MR. ANGUS: Because of the high requirements we probably go about a third, a third, a third. So for every three applicants, I'll go through two and I will accept one. But because of our high requirements -- I like that personally -- I don't have to look through 300 applicants for which two-thirds aren't really liable.

DR. CARTER: Excellent. Thank you very much.

MS HAYNES: My question is for Mr. Mosaros. I hope I am pronouncing your name correctly. You spoke to economic impact. And based on some of the information that I reviewed, can you explain why many of the physicians practicing are opposed to CRNAs, one of the responses from them are that this is going to drive up my costs. And this is going to be costs that I am going to eventually pass on to the patient.

MR. MOSAROS: Sure. Are you referring to the physician anesthesiologist saying that this is going to drive up the cost or the surgeon or both?

MS. HAYNES: Both and maybe practices with CAAs in addition to CRNAs.

MR. MOSAROS: This is definitely not my area of expertise. But my explanation to what I understand -- when you insert individuals into the anesthesia care team model, one physician can cover four rooms.

So, you either have the choice -- if you have to run -- if you are a four-room hospital, you would have to run four physicians, four nurse anesthetists with one supervising physician whether it be an anesthesiologist or not, the same with AAs. So, by actually incorporating the anesthesia care team model it allows you to run more rooms and do more cases at a lower cost.

Does that answer your question?

MS. HAYNES: Yes. And I have another one. For example, when I saw the small surgery centers --

MR. MOSAROS: Yes.

MS. HAYNES: For example, the CRNA, anesthesiologists are saying why would I choose to bring in this additional person.

MR. MOSAROS: Sure. So, I guess where I am with that is I don't believe it's an additional person. The care team model is four people. I actually work at a surgery center. And we have four ORs and two --

MS. HAYNES: All right.

MR. MOSAROS: -- and we run four providers, two CRNAs, two AAs and one anesthesiologist. There is no additional cost. It's not they are going to add a profession to this. They are either going to incorporate AAs in their practice or not. It is strictly related to them. So, if we needed to hire two more providers to run six rooms and there were no providers because there was only one option, I don't believe you're adding cost to the health care.

Does that --

MS. HAYNES: Yes. Yes, it does.

And the reason for my question, as I have said, in seeing this over and over and that's the thought that this is just another person and it's going to increase my cost. It's also going to increase the cost of the patient.

MR. MOSAROS: One example where it would be the opposite is if you were a small facility that were running four operating rooms with four physicians, the cost of a physician versus the cost of someone in the anesthesia care team model is significantly different.

So, one physician can manage four anesthetists. And if you compare all of their

salaries versus four anesthesiologists, there is a significant increase in cost in running four anesthesiologists -- there is also a supply issue for a number of anesthesiologists versus providers.

MS. HAYNES: Thank you.

MR. WELLS: Peter DeForest.

MR. DEFOREST: Good morning. As you heard, my name is Peter DeForest. I'm a CRNA with a master's in nursing anesthesiology, a doctorate in nursing anesthesia practice.

I'm the current president of the Virginia Association of Nurse Anesthetists. I am also a practicing CRNA and the director of services for a critical access hospital.

In my former life I was the director of anesthesia for a large southwest Virginia healthcare system, which I oversaw the staffing and professional aspects of seven rural facilities.

So, to that end, I can speak to a lot of your concerns about the smaller facilities and the actual real world cost of providing anesthesia in rural Virginia in mid to small size facilities.

I would like to take a second to let you know that in principle I am not opposed to anesthesiologist assistants and VANA has not taken a

position against anesthesiologist assistants. We do have some issues, which my colleagues to follow me will point out. But the arguments that have been presented for their utility in Virginia -- but I think my time would be best spent in addressing what I am most familiar with, which is trying to provide safe, cost-effective care in rural in smaller facilities.

I want to point out that you have heard several times that there is no difference between CRNAs and anesthesiologist assistants and that they are held to a very high standard for admission requirements and so forth. And with all of them were aiding in the admission to provide good, safe anesthesia care to the residents of the states and communities that they serve. But there are differences. And the physician anesthetist that said they treat their CRNAs and anesthesiologist assistants the same are probably speaking very truthfully. But that is because they are setting their own perimeters. I mean, I can treat my daughter and my son exactly the same, but that doesn't erase the fundamental difference between them.

The other difference is admission

standards. By all of the admission standards I have found for their programs, if you just look strictly at their criteria, none of those candidates would get accepted into a nurse anesthesiology program.

I personally got -- I was licensed as a registered nurse in 1985. I went back and got a graduate degree in nursing anesthesiology in 1990. And in that interim, my primary nursing education and my nurse anesthesiology education I spent five years working in post surgical settings, orthopedic post surgical settings, in coronary care units and in what we called at the time, cardiothoracic intensive care unit, which we would receive open heart surgery patients and back in the day when things were -- by today's standards pretty barbaric, and we would sit with those patients over night while they would emerge from their anesthetic and all of the various problems that came up during the course of the night with just a fellow on call three floors away.

And there were times when you had trouble with a patient, critical trouble with a patient, and you would be there for five minutes or however long you needed to be until the fellow could make his way down. The fellow staff people on the floor were

busy with their one-to-one patients and you were left with your judgement and professional skills and years of experience to manage that patient until help arrived.

So that is how I came to enter my graduate program in anesthesia with all those years of experience, those weekend nights being alone, having to manage patients with very critical circumstances, with backup, but backup at a distance. And that, I feel, prepared me to begin my study of anesthesiology.

And I admire these kids because it's going to take a lot of backbone to come into patient care as a new patient care provider and anesthesia at the same time. It terrified me and I had five years of critical care nursing experience. So they have a lot of guts. Either they have a lot of guts or being naive, probably a mix of both because we all have that.

You know, it's just in my basic nursing training I had rotations and semester long courses in pediatric care, mental health, public health, critical care, things that these kids, these young people, coming into the program won't necessarily have. So there is a difference.

There is also a difference in how CRNAs and anesthesiologist assistants are reimbursed. Now we heard several times that there is no difference in how insurance sees non-physician anesthetists, but that is not entirely accurate. It's only accurate if you look at a very narrow segment, which is the care team model.

So they have a four to one ratio and that's all fine and good. They can get reimbursed as medically directed anesthetists. If they go to a five to one, then suddenly all bets are off. If you have CRNAs in that practice, those CNRAs now become supervised.

There is a difference between supervision and medical direction in the eyes of CMS. And CMS is the agency to which other agencies refer, and defer in many instances, regulation and payment situations.

So the difference is that a CRNA can bill and perform anesthesia without the medical direction of a physician anesthetist whereas the CAA cannot. That is why I can be the sole anesthesia provider in Patrick County, Virginia day in and day out, year after year. There is not a physician anesthetist within 30 miles of me. And our hospital is able to

get reimbursed for my services and have safe, cost-effective patient care provided.

Another clinical situation in which I work is a surgery center in a small city and they came to my partner and I because they had a physician anesthetist that they had to pay a fairly high salary because a large fraction of their patients are CMS patients, so, Medicare, Medicaid, they were not charging enough. They were not getting reimbursed enough to pay the physician anesthetist's salary. They could only recoup two-thirds of the salary.

So they turned to us as known in the community and said can you guys help us out. And we are now providing their anesthetic care. They are at less than their reimbursement cost from their insurance billing. So not only do they get safe cost-effective anesthesia care, but they get to keep a little bit of money on top of that. So there are differences.

And I want to note that the anesthesia safety today is absolutely phenomenal, and as nurse anesthetists we owe a lot of that advancement in anesthesia safety to colleagues that have preceded us, physician anesthetists, nurse anesthetists, all

developing safety standards, quality management.

They have advanced anesthesia safety to the point where for a healthy individual undergoing routine surgery, they are extremely safe, very low risk of complications. And studies have shown that CRNAs providing care is equally safe and comparable to other types of physicians, or other types of providers.

To speak to the cost, the downward pressure in salaries that they mentioned, it is interestingly enough that only the physician extender salaries that increase. So I wanted to point that out. The physician anesthetists salaries maintain the same. There may be advantages to the department in certain facilities, but overall it's the extenders that are having the downward salary pressure. And that's part of the reason why my membership has prompted me to come here to address some of the questions that you might have because they are concerned about competition and downward pressure on salaries.

And we all have concerns about the financial stability going into what could be a period of extended healthcare reform or pressure downward. Cost pressures are going to be placed on everybody. We don't want to be put in a uniquely

weak position.

So there's an interest in our prior membership to see that we have a fair playing field. A level playing field is good for all. I would like to see all providers being able to provide care at their level scope of practice.

And to that end we would like that to be a consideration. When we look at the criteria for this study, one of them is are there alternative regulations, which would adequately protect the public, but might also meet the needs that are being proposed or being fit for the anesthesiologist assistants.

And one of those alternatives that I think I would strongly urge you to consider would be seeing about the feasibility of having all anesthesia providers that are licensed and board certified be able to practice to their full scope of practice and take down barriers to that level playing field that currently exists for CRNAs. I would be happy to take your questions.

MR. WELLS: Thank you.

Janet Setnor.

MS. SETNOR: Good morning. Thank you for your time. I'm Janet Setnor. I'm a 1998 graduate

of the anesthesia program at Old Dominion University. I just recently retired at the Air Force from the United States Air Force Reserves after 26 years of service.

While in the Air Force I provided anesthesia care independently at both stateside medical treatment facilities and also locations such as the last deployment to Afghanistan.

During my deployment, I was both the anesthesia leave with oversight of three anesthesiologists and three CRNAs in our largest in-country trauma center. And we also cared for locals as well as our warriors.

Many times I was the sole anesthesia provider at an operating base with no other anesthesia support for hundreds of miles. Why was I entitled to practice independently? Because every objective and critical study has proven to the United States Military that CNRAs provide the same level of quality care as that provided by our MD anesthesiology colleagues.

Therefore, I'm here today to provide you with the prospective on behalf of the certified registered nurse anesthetists who practice in the military hospitals here in Virginia. CRNAs have a

long history of providing anesthesia care to our warriors since the civil war.

We have practiced in our branches of the U.S. military, and interestingly, none of the U.S. branches require CRNAs to be supervised by an MD or an anesthesiologist. Nurse anesthetists, as I have mentioned, have been the main anesthesia providers to U.S. military personnel on the front lines since the civil war.

Additionally, CRNAs are the prominent anesthesia providers in the Veterans Affairs Health care system facilities. Anesthesiologist assistants are not authorized to work at anesthesia providers in the armed forces. Unlike the CRNAs, AAs must be required by an anesthesiologist only whereas anesthesia providers in the armed forces CRNAs and anesthesiologists alike must be and are trained to be independent providers and ready to individually deploy to the front lines at a moments notice.

Our operations demand the ability to practice independently in order to save the lives of our warriors and the locals that are injured in any type of contact.

In Virginia, CRNAs independently provide anesthesia care in all four of our military

hospitals; Naval Medical Center, Portsmouth; Fort Eustis; Langley Air Force Base and Fort Belvoir. During the past seven years of working with the joint services defense health headquarters, there has not been a single occassion in which the use of AAs have been pushed forward for consideration.

It is likely that even if anesthesiologist assistants are licensed in Virginia, they will not be utilized in our military hospitals; therefore, it will not increase the access to care to the members of our military, our veterans or their families.

So I ask you to consider whether it is feasibly or fiscally responsible or is it in the best interest of anyone that for every two to four AAs hired, you will need to hire at least one anesthesiologist assistant to supervise. This will lead to increases in cost to the patient, the facility and the Commonwealth.

The question that was asked earlier about the care in the smaller hospitals. Many of our military facilities do not have anesthesiologists present. If we increase the model to include anesthesiologist assistants, we will have to hire probably 75 to 84 is the number that we looked at, anesthesiologists to cover the shifts in those

facilities. So, therefore, that would be a huge increase in cost.

Recently the Department of Veterans Affairs granted full practice of authority to advanced practice registered nursing regardless of the state requirements that limits such full practice authority.

However, the CRNAs were not included in this expanded practice role. The reason for this as safety, or as many studies have shown, is not because of safety concerns but because the MD colleagues of ours have claimed and stated that there is no anesthesia provider shortage in the VA system. So full practice authority was not necessary for CRNAs in the VA system.

So, as a final point, I would like to say that I come from a family of warriors. My father-in-law was a WW II fighter piolet. My father was the first sergeant to Col. Powell. My husband was the architect and leader of the airwar during Desert Storm. My son is a marine and had four combat deployments, one of which I was -- and I have to say not many marines can say they took their mother to war with them.

But as a standard of care, I am now a

veteran. And what I expect at the head of my bed is somebody to be able to practice independently, to know how to act spontaneously in the event of a medical emergency, and to know who to call if they need the assistance. So those are my expectations of care for myself and the veterans and their families.

Thank you for your time.

MR. WELLS: Dr. Fallacaro.

DR. FALLACARO: Thank you. My name is Dr. Mike Fallacaro. Like Dr. Frank, I'm a native of Buffalo, New York and a Bills fan. But I've been in Virginia for 19 years.

I'm a tenure full professor and I chair the Department of Nurse Anesthesia at Virginia Commonwealth University. I am here to represent the university of my 160 graduate students, and I applaud the students for being here today from the AA programs. I could have brought my 160 students into the room, but they are providing care at this time to the citizens of the Commonwealth, across the Commonwealth from Big Stone Gap to Portsmouth to Alexandria.

Our program started back in 1969, at what was then the Medical College of Virginia. We have

been training students ever since. We are an acknowledged program. The first program in the United States to create the Master's of Science and Nurse Anesthesia. And a few years ago we were the first program in the United States to create the Doctor Of Nurse Anesthesia Practice degree. And for the last 12 years we have been recognized by US News and World Report as being the best nurse anesthesia program in the nation.

And I take pride in that because it is the quality of our graduate students. It is the quality of our facility. It is the support from the institution and the Commonwealth, itself, that has all contributed to that success, which I hope and trust translates down to the care of the citizens of the Commonwealth are getting.

In terms of the training itself, I said we are across the Commonwealth and that's because while our base is here in Richmond, in 2004 we were approached by the CEO, the director of the Southwest Virginia Higher Education Center, saying there was a significant need in and amongst the coal fields of Appalachia for quality anesthesia care.

And in 2009, we were approached by the Roanoke Higher Education Center with the same

concerns. And since that time we had graduated over 130 students in this region of the United States. And 80 percent have kept employment within the region and 70 percent at the same institution in which they trained. We have 44 clinical sights across the state; again, Big Stone Gap, Pennington Gap, Wytheville, Portsmouth, Alexandria -- I could go on and on and on. These are clinical partners of have found great benefits in the resources our department has been able to provide.

And it's this resource, this issue that I want to talk about. I have concerns when I hear my colleagues from the anesthesia assistant program saying they have an interest, a real interest in opening programs here in the Commonwealth of Virginia.

If you look at the type of cases that anesthesiologist residents need, nurse anesthetists and graduate students need and AAs need, there is a great deal of overlap in the type of procedures they need in order to meet their certification and licensing requirements.

I can tell you that at the VCU Health Center, 1,000 bed hospital, right now we have nurse anesthetists training, and we have a

anesthesiologist resident training. And we have no room for any other trainees. We have no room for any other trainees. We just do not have the space to add them. Because, again, we are competing for the same limited number of cases, especially specialized cases in terms of pediatrics, regional anesthesia, cardiac anesthesia and the like. So, finite resources are an issue.

And we are also interested in terms of our educators, themselves. And something that I thought about is if you hire an AA into an institution which is also training other providers, well, then the AA cannot supervise a graduate nurse anesthesia student during their training.

So, not only does the AA take the job away from a CRNA graduate, but they also cannot educate a student. So we not only lose a job placement, but we also lose a training opportunity or more depending on the number of rooms these folks are in. So, again, our training would suffer. It would hurt our training in terms of where we stand.

In terms of applicants, I turned away over 110 qualified applicants this year. I accepted 43 graduate students. Now you might ask why didn't I accept more, and it's because of that finite number

of training slots.

We heard from our colleagues that the Fairfax people have 40 openings. I can tell you that we do have training at Fairfax. We do train our graduate students up there. But the institution only allows us to train one student there, one student there. We have a well-oiled machine. We have a proven track record of producing high quality people. If you would like more providers, open the spigot in terms of training sites. You don't have to create a new program. We have one that has demonstrated excellence. And we are ready and willing to work to meet the needs. And we also have the data to show that the vast majority of our graduates will stay within those places were they learned.

And, again, I'm concerned about your criteria in terms of training that it will damage the training that we are doing at Virginia Commonwealth University.

So as far as the scope of practice and being distinguishable from other professions, we heard from the physician colleagues here that they make no distinction.

So, again, what you are talking about is

replacing a provider with another, replacing a provider because they are not bringing any demonstrable difference in terms of quality, in terms of techniques or things that they are able to do and function that are different from what we are already doing.

To kind of summarize things up at where we are now, I had the pleasure a few weeks ago standing with Governor McAuliffe putting the shovel in the ground to open an 82 million dollar new VCU School of Allied Health Professions. The third floor of that building is an expansion that was granted to us from the Commonwealth to expand our program.

It is going to have a world-class simulation laboratory in centering patient safety. A doctor of nurse anesthesia practice program that was created at VCU and was approved here at the Commonwealth is again, a model being used around the nation. The program is 93 credit hours, three years minimum in duration.

And, again, the focus is entirely on patient safety. So, again, it is a knowledge program. Our program meets the prefered passing rates of the national board for certification and recertification in the United States, which also

contributes to our national ranking.

So, again, the Commonwealth is making an investment into our program and we are very grateful. The other thing is not only is the Commonwealth making an investment in Virginia Commonwealth University, but also Old Dominion University, the other training program here in Virginia.

And, finally, the Southwest Virginia Higher Education Center and the Roanoke Education Center, again, we're citizens of the Commonwealth taking some of their tax dollars and making investments in these regions.

And, again, in many of these regions, as Dr. DeForest attested to, our providers are the only anesthesia providers out there in these areas. And in terms of quality, while there has been argument for years and years and years, there is no demonstrative difference in terms of outcome, whether your anesthetic was delivered by a nurse anesthetists or anesthesiologist, it's just not there. It's just not there. And I challenge anyone to bring data forward to say it is there without it being refuted.

My colleagues talk about wanting

competition and there are representatives from the American Society of Anesthesiologists here. Here is how I see this competition going. Well, they want competition between nurse anesthetists and anesthesia assistants. They don't want competition between nurse anesthetists and anesthesiologists.

And, so, if you can take and license another anesthesia provider that is a dependent provider, that has to work under you, you can control their education, control their practice, ultimately control their salary and eliminate your own competition.

So when they speak of competition being good, it works both ways. So I ask the Board to consider that in terms of how competition can increase.

So to conclude in terms of feasibility -- I thought about this. I just came back. I was fishing. I actually caught a marlin so I was very excited yesterday. And I got back and I was thinking about feasibility. It's probably feasible to do anything.

Now, is it wise to do anything. In my mind, I based feasibility upon need, upon need. So is there a shortage of anesthesia providers? I

would argue there is not. And if there is a shortage we have a mechanism, well proven mechanism in place, to address that today, today. I can accept more students today. If Fairfax opens more training spots, bang, I'll put you 20 in there. We have the mechanism to do it and the proven track record to do it.

So if need's not the issue, well, maybe it's quality. Well, we have no difference. Well, maybe it's cost. The only thing that's going to increase in cost is if you damage the nurse anesthesia training program that is in place. And if in these small hospitals we have to hire an AA instead of a CRNA, well, now you need an anesthesiologist. So the cost will increase. Control over the speciality will increase and there will be winners and losers. Probably the nurse anesthetists are going to be the losers in this type of competition, if you want to call it that. And, so, I would argue against that.

Anesthesia, despite what people will say, anesthesia is not the practice of medicine. It's not the practice of nursing. Anesthesia is a body of knowledge onto itself. And it is only those who are properly trained in credential within that body

of knowledge, that it can be part of their scope of practice.

So instead of saying anesthesia is the practice of this or this, it is within the scope of practice should you so deem it to be.

My nurse anesthetist students comes as nurses, registered nurses. They have held the hands, wipe the brow, given the bed bath, worked their way all the way up. And they are required to then do critical care nursing.

Our physician colleagues have had that same approach. They start as residents. They do basic care all the way up. Now, again, people can say well, we don't see any difference between outcomes between nurse anesthesia and anesthesiologist, people were not looking at the right things because there is a human factor there which, I think, does make all the difference. And I'm available for questions.

Thank you so much.

MR. WELLS: Dr. Apator.

DR. APATOR: I'm not as articulate as Dr. Fallacaro. So I apologize in advance.

Good morning. Thank you for having me. Thank you for giving me the opportunity to speak.

My name is Dr. Nathaniel Apator. I'm a nurse anesthetist and the director of the Old Dominion Nurse Anesthesia Program.

I have been providing anesthesia in the Commonwealth since I got out of anesthesia school and I was working in Virginia. I'm a retired army lieutenant colonel. I have been decorated for heroism. I was the president of the National Board of Certification of Research Patient Nurse Anesthetists. I'm on the certification board, the National Certification Board for Midwifery. I know a lot about anesthesiologist assistants. So I'm not a hater. My best friend is an anesthesiologist assistant when he became a nurse anesthetist.

So I don't hate physician anesthesiologists. I don't hate AAs. I'm not a hater. That's not who I am. Although don't look at my Facebook page after a full day at the hospital. I do work at the Portsmouth Naval Medical Center. In addition, I provide independent anesthesia care there. And, again, the program for the nurse anesthetist at Old Dominion University.

So I'm not here to talk about the shortage of anesthesia providers in the Commonwealth because I believe that is largely fake news. I would like

to point out to begin with that anesthesiologist assistants are not some group -- I'm sorry. My friend tells me how when he went to AA school, he referred to the have and have-nots. What he meant by that was that there are a certain number of AA students who have no medical training at all, zero. And there were certain ones that had previous training. He said that the knowledge deficit -- because he was in agriculture as an undergraduate. He said the knowledge deficit was dramatic. And he didn't know how much he didn't know until he got into the profession. And, ultimately it lead him to become a nurse anesthetist because he wanted to practice independently.

There is very little safety data on anesthesiologist assistants. There is one study that's out there and I read it. I'm a nurse scientist. I have a PhD in neuro science and I'm pretty good at disecting research.

I would like to reemphasize what Dr. Fallacaro said about the training sites. We took eight students last year. And the reason we took eight students was not because we didn't have enough applicants because I have plenty of applicants. The reason we took eight students is because we have

trouble finding clinical training sites.

In the last year we have done a very good job of increasing that. A lot of our students have to leave the state in order to get -- we send students as far as Columbus for pediatrics rotation because it's limited resources with regard to educating anesthesia students. We have to compete with providers from all over the US. And there is just a limited number of clinical training sites.

And it may be feasible to start an AA program. But I think it would really damage liability to put nurse anesthetists out into the community. We provide the nurse anesthetists for all of Hampton Roads, almost every hospital from Portsmouth to Chesapeake and Suffolk and Virginia Beach are staffed by my students.

You know, it's interesting, I would like to address briefly criteria three regarding the autonomous practice. I think that you can either say you're autonomous or you're not autonomous. I heard one of the previous speakers refer to the L&D sometimes. What that means is you are left largely by yourself in an emergency situation.

I heard another reference to a four to one ratio. What does that really mean, a four to one

ratio? It means that the physician anesthesiologist is responsible for four anesthesia locations.

So how would that work if there were two problems in two different places? Who do you want providing care? Do you want the person who is an agricultural major, who was trained to perform a certain series of steps in an emergency or do you want a nurse anesthetist who has had years of critical care training, who is doctorately prepared? Which of those two providers would provide more independence, and would you want your grandmother taken care of by them? I mean, that's really the bottom line. It's who do you want taking care of your granny because patient care trumps everything in my humble opinion.

So, you can talk about independence, but if there is a four to one ratio, it means that even the physician anesthesiologist can only be at one place at one time. So do you want the agricultural major or do you want the critical care nurse with a doctorate degree?

I've spoken to a lot of educators around the country in my various roles. And there are a lot of AA practitioners in the Commonwealth that were in various places. Does that make anyone

question why that is?

Well, I'll give you one alternative hypothesis. In talking to my friend and others like him, a lot of the AA training programs don't acknowledge or downplay the fact that AAs can't practice all around the country. So many people go to anesthesiologist assistant programs. And then they find out when they come back home that they can't practice.

So I would argue that some of the people in this audience are arguing for AAs because they are members of the Commonwealth of Virginia but, in fact, they may not have been told up front that they couldn't work in the Commonwealth before going to AA school.

Our physician anesthesiologist colleagues claim that there is no difference in the way they treat nurse anesthetists and AAs. Well, that's because they don't deeply know the difference between AAs and nurse anesthetists because the anesthesiologist colleagues has the following -- it's the physicians are at the top of the anesthesia care team and everyone else is below.

So they don't really get into the details of how nurse anesthetists are differently educated

and AAs are trained. There is a difference. We are educated to make decisions. All nurse anesthetists students have to provide care plans, which means the night before they care for patients, they go home and they study about that patient and they come up with a plan based on the patient's physiology, anatomy, pharmacology, path of physiology, and then they present their plan.

This is dramatically different to how the AAs are trained, where they get to the operating room and the physician anesthesiologist says do this, this, this and this, and let me know if there is a problem and then leaves the room.

It's a different way of educating people. In one case, nurse anesthetists are educated to be critical thinkers. In the other case, the anesthesiologist assistants, who are very fine people, I have nothing against them, they are trained to be dependent on a physician anesthesiologists.

And because nurse anesthetists are independent practitioners that can work with other physicians specialities, that increases access to care for citizens of the Commonwealth.

Finally I would like to close by saying I

don't see myself as a physician extender. I don't see myself as a care extender. I see myself as a care giver. And I think that's a fundamental difference in the mentality of the two professions. I'm a care giver. I'm not extending anyone's services. I'm a licensed credential provider who is well educated in the art and science of anesthesiology.

Thank you for your time and I'm open to any questions. Thank you very much.

MR. WELLS: Ms. Satterlund.

MS. SATTERLUND: Good morning. Thank you for your time. I'm Michelle Satterlund. I'm with McGuire Woods Consulting and I represent the Virginia Association of Nurse Anesthetists. And I apologize I think I may have signed up on the wrong sheet. I'll provide the summary to VANA and I apologize for that.

I thank you all for giving us this opportunity to speak. I want to highlight what VANA's president, Dr. Peter DeForest mentioned. We are not opposed to AAs. We understand that in the world of health care there are many roles that are served.

But as you look at AAs in Virginia and as

you go through your criteria, it is critical that you look at the services that are already provided in Virginia. As you heard from Dr. Fallacaro and Dr. Apato, we have CRNAs who would love to practice in Virginia. We have a pipeline of ready people and you have to ask does it make economic sense to deviate from that pathway to start a licensure process of an entirely new group that will require the immediate and direct supervision of anesthesiologists.

If Virginia has access to care programs -- problems specific to anesthesia care, how will providing another provider with an additional provider in any way impact that access to care issue.

And I know in the report that you provided some workplace data information and we have some concerns with the data. I'll just be very candid about that. And we are going to be submitting written comments on it before the July deadline with some of our own data that we find that Virginia does not have a shortage of anesthesia providers. And that is backed up by the Herser (phonetically) report that you provide in your draft document, as well as the Veteran Administration and the

National Association of Anesthesiologists, that when they were looking at the issue of shortages, determined that there was no anesthesia provider shortage nationally.

So it's critical that if you think there is a shortage, can we address that shortage by what I would say by taking care of the low-hanging fruit, opening the hospital clinical trainings, allowing those other students who want to be practicing in Virginia as CRNA students, allowing them to do that, looking at the scope of practice issues that are impeding CRNA practice.

I know that there are misconceptions in many hospitals that anesthesiologists has to practice with a CRNA. That is simply inaccurate. The law in Virginia says that a CRNA practices under the supervision of a MD, dentist or podiatrist, does not require an anesthesiologist and it does not require that that supervision that that MD be on site.

Now because CRNAs practice in a surgical team model, there is always going to be a surgeon there. There always is a physician. But that individual may have no anesthesia training.

So that particular facility often,

particularly in the rural areas, relies on the knowledge, the anesthesia knowledge and training of the CRNA. So to say it's equal, I think, is inaccurate, to say that CRNAs and AAs are equal in training. CRNAs practice independently in a substantial number of the rural facilities in Virginia. And I don't see that if you plan to license these individuals that it will have any impact whatsoever on the access of care in the rural and small facilities.

We stand here ready to serve as a resource. I know you have a big job in finalizing the report. But I urge you to look comprehensively at this issue and not just at the very small criteria, is it feasible. Just about anything is feasible. But what will be the impact of licensing a third provider.

I thank you and if you have any questions, I'll be happy to answer them.

MR. WELLS: That's the end of the printed list. Is there anyone who would like to speak that has not spoken or anyone who would like to return to the microphone?

MR. BALL: Mr. Chair, we have a few concluding remarks.

MR. WELLS: Identify yourself please.

MR. BALL: Brian Ball with Williams Mullen and Katie Payne, also with Williams Mullen. And there may be others who wish to comment.

First of all, I mentioned earlier that we would like to have a CAA school in Virginia. That's the goal of the CAAs. I want to reassure the gentleman from VCU and Old Dominion, those schools wouldn't be sited and that no one is looking to take a dollar from those schools' funding streams, which I know is very important to them. It's unfortunate that it's being cast as a competitive thing because we really don't look at it that way.

The other thing -- two other things I wanted to mention briefly. A comment was made we don't oppose AAs, but -- and then we heard a lot of reasons why we shouldn't have CAAs in Virginia. But I want to go back to the practice location list that I gave you a few minutes ago. And I just wanted to take off the university teaching centers that use CAAs, University of Colorado, University of Florida, Indiana University, St. Louis University, University of Cleveland, University of Vermont -- I mentioned Washington Hospital Center and I think that is affiliated with a teaching school -- University of

Wisconsin.

So all of the things that you heard about, this doesn't work and they have to work under a physician anesthesiologist, which is true, all of those institutions have managed to accommodate AAs, and as you heard from three, if not four of our physician speakers today, they see no functional difference when they are running operating rooms as far as the anesthesia care team, long, established, safe. They see no difference in using CAAs or CRNAs.

The last thing is I think there was an appeal made for you-all to consider whether CRNAs should practice independently. With all due respect, the General Assembly has considered that question twice over the last few years and said no, the CRNAs should work under the supervision of a physician, podiatrist, a dentist.

And, secondly, the VA most recently after a lot of consideration of opening a new practice concluded that there should be supervision. So that is not really the charge here. We saw the letters prepared by members of the General Assembly who asked you to look into this. And it was focused on CAAs and whether they should be able to pursue

licensure and work here in Virginia.

Thank you.

MS. PAYNE: And just to follow-up, Katie Payne again. Just to follow-up with a few of the other items mentioned. Mr. DeForest said at the beginning that a CAA would not qualify to get into a CRNA program, neither would a medical student. And conversely a CRNA would not qualify with their prerequisites and their background to get into a CAA program or into a med school. There's two different tracks. So it's correct. It's a factual statement, but it flips both ways.

There is a lot of discussion about the small rural hospitals and the CRNAs being able to work independently. As Brian just said there are two cites in the state code that say CRNAs must be directly supervised by a physician, podiatrist or a dentist. That is a different model than the CAAs. They are correct about that. But they cannot practice independently. They must be directly supervised.

So, I think it's misleading to say cost is going to go up because a CAA has to be supervised by a physician anesthesiologist. It's already the case that a CRNA has to be supervised by a physician. So

there is really no difference there. There is a difference in which provider it is. But there is no difference in the fact that they both have to be supervised.

There were some references made as to the loss of spots at schools or for positions. As we testified earlier, I don't think that's the case. There may be one thing we need to add on that point, but, again, we are not trying to take away spots from the CRNA programs. There are jobs available to them. This is a separate class of providers.

Dr. Engels, do you want to come up and speak to that issue?

DR. ENGELS: Yes.

I don't want you to think that we weren't paying attention to the comments. But during this talk we got on our phones and went to the website, gaswork.com, which is a website for a listing of anesthesia jobs.

And as of this meeting, there are 167 CRNA positions advertised in Virginia. Some of those include part-time positions. There are 78 full-time positions for CRNAs advertised at the time of this meeting on gaswork.com. As I mentioned, our practice alone has 40 open positions right now.

MR. WELLS: Thank you very much.

MR. DAVIS: Thank you very much. My name is Thomas Davis. I'm the vice chair for Clinical Affairs with the Virginia Commonwealth University.

I would like to address a couple of the points today that were made here especially no competition between an AA program and our existing nurse anesthesia programs.

By their own information AA programs need to be ankled to an academic medical center. The academic medical centers within the Commonwealth of Virginia are associated with the programs -- so we have students at UVA. Obviously, we are based at Virginia Commonwealth University. We also have students that were at Memorial Hospital and several facilities around the region.

So the main concern we have, as Dr. Fallacaro spoke, is clinical education. That's the number one limiting factor of the number of nurse anesthesia students we can accept. As he said, we are turning away as many as 100, if not more of qualified applicants.

As a matter of fact, this last group of students in the Northern Virginia area -- we actually have a satellite classroom in Alexandria.

In the Northern Virginia area we had over 30 applicants for only six positions. So we are limited primarily by our first-year student placements. And that was Dr. Fallacaro's point with Fairfax Hospital. Fairfax Hospital only accepts one first-year student from our program. They also accept students from -- they only accept one from VCU.

I am constantly searching for additional clinical replacements. And as I find additional clinical replacements, we accept more students. And accepting more students equals more graduates.

So when you replace a CRNA provider with an AA that cannot supervise a nurse anesthesia student, that's one less available room for us to put a nurse anesthesia student. When you introduce an AA program, you're starting to compete for finite resources and that actually stands to reduce the available resources for both nurse anesthesia students as well as anesthesiologist residents and hence, the potential outcome of no net game in the number of providers generated in Virginia every year.

So I would be happy to talk to anyone who has a need at their facility. As Dr. Fallacaro

stated, over 70 percent of our students would take employment -- so it's a proven record. As a matter of fact, even one of the other gentlemen spoke to being able to pick and choose exactly who you want due to the quality that they seek throughout their education program.

I would also like to talk about just one other point about CRNAs practicing independently. While we do require physician supervision, the surgeon actually covers that and we have many, many, many rural sites across Virginia.

As a matter of fact, Dr. DeForest works at one, where there are only CRNAs practicing. So the replacement of a CRNA with an AA within the institution care team model has little impact on cost. The replacement of an AA in one of these critical access hospitals, small rural hospitals with an AA automatically brings the requirement of a physician anesthesiologist to the facility.

So the physician anesthesiologists are in a similar situation -- CRNAs as far as their availability. And that would not only cause a difficulty with being able to attract anesthesiologists to these small rural areas, but it would also increase the cost.

So instead of having a single CRNA provider, you would have a single anesthesia assistant plus a physician anesthesiologist at these rural sites. Those are my concerns.

MS. SUTTERLUND: Thank you again for your time. I just want to offer one response to Mr. Ball and Ms. Payne's comments. Again, Michelle Sutterlund on behalf of VANA.

Just to clarify the General Assembly has not looked at the issue as supervision for CRNAs in many years. Brian Ball indicated that had been a recent discussion. What gets confusing is that CRNAs are licensed as nurse practitioners. And if you start looking, you'll see carve out after carve out for all the categories of nurse practitioners, which include nurse midwives, CRNAs and then your nurse practitioners. Nurse practitioners do practice collaterally in Virginia.

When that discussion came about in 2012, the anesthesiologists with NSV and VANA looked at that issue. And the decision was made not to include CRNAs. However, the supervision is that. It's just a word on paper.

As you heard from practicing CRNAs, they are often the only anesthesia providers in many

rural facilities. They are often the only anesthesia providers when they are on the front lines in Afghanistan or in our military hospitals. So, yes, there is the word supervision on paper. But that's all it is.

So, I just wanted to clarify that. And, again, as we just pointed out, we are not concerned about, you know, making sure that another provider who is kept down. That's not what this is about. It's looking at the existing pipeline that we have in Virginia. If there are issues to care, and I looked at the original letter asking this committee to study it. I didn't hear that -- well, I'll quote, there is a national shortage of anesthesia providers including nurse anesthetists. That is inaccurate. I don't recall them ever coming to VANA and talking to us about our numbers.

So I think it's important to clarify. I think there is a general sense of shortage. But it's simply the data does not indicate that is accurate.

So thank you very much again for your time. And I appreciate all the work this Board is going to do.

MR. WELLS: Is there anyone else that would

like to speak? Are there any students that want to get the experience?

MR. LINDSEY: Good morning. My name is Ray Lindsey. I'm a nurse anesthetist since, I guess 2000. And I just want to clarify a point. Someone mentioned GasWork as an example of need for anesthesia services in Virginia. And I don't think that is a reliable source. I work at a facility that advertises on gasworks, but it's filled they just want to keep on advertising. I just want to clarify that point.

Thank you.

MS. BULLIGARD: Good morning. My name is Trinal Bulligard (phonetically). I'm a student, first-year and first-month student at Case Western in D.C. I am a resident of Arlington, Virginia. I've been living in Arlington for three years, and I lived in Alexandria previously.

As a resident of Virginia, I would like to be able to practice in the State of Virginia as a CAA upon my graduation in 2019. I did not choose this program believing I would be able to practice in Virginia. I did my research and was fully aware of the states where I would be able to practice. With that being said, I would like to practice in

Virginia and continue to live in the state of Virginia.

Thank you so much for your time.

DR. DEFOREST: I just wanted to give one quick little personal experience. I can tell you we run two to three ORs. There is absolutely no way that we could afford or recruit or retain a physician anesthetist.

I have one full-time provider and that would be myself, and then three per diem part-time people that help cover me if I'm off or if I have a busy day and running two rooms, then they will come in.

My hospital administrator has written a letter to the Board explaining that physically that it would just be impossible to carry the burden of a high cost anesthesia provider, a relatively high cost anesthesia provider.

And in my past experience as director of anesthesia for a health system, five of my seven facilities were CRNA only practices. And it was, again, impossible for us to be able to carry the expense of a physician anesthetist at those smaller facilities, the largest of them having only four ORs.

Again, I heard descriptions that you could have four to one. You would have four anesthesiologist assistants and one physician anesthetist, that still is a much greater expense than having four CRNAs.

And also what happens after hours? Does the physician anesthetist carry all the calls because the anesthesiologist assistants cannot carry the after hour calls, weekends, nights?

So it is just not feasible in many parts of the state. So restricting the pipeline of CRNAs that are trained to cover the rural needs of the Commonwealth would be imprudent in my opinion.

Sometimes it's difficult to find CRNAs that are willing to come to the small facilities as well because a lot of the anesthesia care team practices are so restrictive that if you've been in one of those for years when you been through school, if you've been through school, you basically lose a lot of capacity to comfortably work without the presence of a physician anesthetist.

So it would be beneficial to access the care for rural facilities and also to have the promotion for a full scope of practice for nurse anesthetists so that they can maintain their

independence, practice skills and be able to better meet the needs of rural facilities and those certain areas.

Thank you.

DR. FALLACARO: Again, very shortly.

The issue I'm hearing is that there is a work force shortage. And in the case of the Northern Virginia area we have many, many qualified applicants and we have affiliation agreements in place with many of the facilities that were spoken about where there is 40 people short or such. I can have students, graduate students, in these facilities tomorrow. Within weeks I can put them there and they will graduate and then, again, we have data to show that they will stay there.

So if the issue is we have 40 or such shortage and we need more people, and we have room to take trainees from another site instead of another school, it is really the issue.

If it's a work force shortage issue, I would be delighted to provide trainees there that also provide service while they are there. Immediately we have the mechanism in place and it's a state funded, state supported mechanism.

So I just throw that out there. It's

there. It's ready to go. I do not hold any political office. I'm not the president of any political association. I'm an educator. And I just look at it as they need people and we would be delighted to put them there. It would certainly help VCU and we also want to help our partners and we have a record of doing that.

DR. FRANK: Dr. Frank once again.

I want to make it clear. It was said earlier that anesthesia is not a medical practice. It is. I was a surgeon before and then switched to anesthesia. And after relearning what a stethoscope was, I realized I had to go back and recollect on medicine. With a diabetic, a cardiac patient, I had to know their medications. I had to know the side effects of those medications. And on top of that I had to know how those medications effected the care in the operating room under anesthesia. I also had to learn much more depth into physiology, anatomy and everything. So that was one point that I wanted to clarify. It is a medical profession. It is a medical speciality. It's not just an area outside of medicine where you treat people.

And, in my mind, it does require a physician to lead the team and taking care of those

patients. Now with that being said, in rural areas and in the military you are dealing with very young individuals, who are trauma patients mostly. In the VA hospitals you have some sicker patients as well. But when you are in the military, which I applaud them for doing so, I think there is a little bit of a difference in practice there and simply dealing with trauma, which is something I deal with everyday as well.

Another point I would make is that being a clinical administrator as well, one of the troubles we find is having quality nursing in the hospital, not just in anesthesia. Right now we find having nursing competencies for covering the recovery room is difficult to find now. We are having difficulty in finding nurses who have ICU experience to come and start covering the recovery room in that area and trying to make that a uniform process, which is in a number of institutions around the country as a standard of care. It's very difficult to meet that.

So I applaud them in saying that they can pick up and graduate one nurse anesthetist, but I find that with the shortage of nursing that we have in our country, I question how much -- I've seen a lot of students who come through who graduated from

nursing school, do their ICU training and now they are in anesthesia school. And that is not to say that they can't do that. I'm just saying that if we start to push that process through, it's taking away from the care giving in other areas of medicine that is requiring of nursing needs that need to be felt.

So the anesthesia assistant programs actually help kind of fill those areas in that regard as well too. And in a lot of different states they are saying they are not licensed in other states, but that's because it's a process that they have been fighting trying -- and have been beaten sometimes against, you know, in order to get a licensure in other states.

I believe in the care team model. I think it's the safest way to take care of the patients in the operating room. I believe also in rural areas it's very hard to meet that care team model. And, therefore, there are advantages to having potential nurse anesthetists as well taking care of some of those of patients. But one of the senior AAs that I work with, any of the senior AAs I work with, could also easily work independently in that regard because they have that level of experience and care.

And that's why I also say that they are

equivalent in practice, scope and everything that they can do. That they can do just anything the CRNAs can do, the AAs can do just as much. So, I'm not sure if there is anything more I can add to that. But I'm open to questions.

MR. FALLACARO: Again, I couldn't disagree more with our last speaker in terms of anesthesia being the practice of medicine. Those are political terms. If anesthesia is the practice of medicine then you better call the police today and arrest me because I'm practicing it.

If the American Medical Association says anesthesia is the practice of medicine, what's not the practice of medicine. If a physician goes and takes the blood pressure, should I say you are practicing nursing illegally or is it all the practice of medicine.

Again, it is within the scope of practice of people who had been properly educated and trained to practice in such a domain. And it's the needs of the patients at that specific moment in time as to what types of services they need. So, again, I couldn't disagree more in terms of that designation.

Finally, in terms of applicants, our applicants -- they want to come to nurse anesthesia

school and they are filling our intensive care units. I'm not too concerned about there not being enough applicants for our programs. What I'm concerned about is that I'm turning too many of them away.

MS. SETNOR: Colonel Setnor again.

I just have to clarify a point. While our wounded overseas are young and healthy, they come in with such trauma, you can't imagine, open head injuries, closed head injuries, limbs that are dripping off of them. These are not well people. They might be young and healthy, and that might be something that helps to keep them alive.

But many of my military colleagues, who are sitting here in the audience, will tell you today that many of the patients that we took care of, both in Afghanistan and in Iraq, any place the military is deployed, we have to take care of the local nationals as well. Those people are not healthy. And we have to determine their health status sometimes without a health history. And we find out as the case goes along what the issues might be. And if we weren't trained to be independent providers, we would not be able to accomplish the 97 percent of our soldiers that are coming home in-

tact.

So just to clarify, the folks that we take care of, yes, they are young and healthy. But they are in some cases close to mortally injured and we take care of them successfully, independently and bring them home.

Thank you.

MS. KELLY: Good morning. I'm Martha Kelly. I'm the administrator for Virginia Anesthesia. We are a mid-size anesthesia group down in Williamsburg, Suffolk and Newport News, Virginia.

We have not been fully staffed for the past three years with our CRNAs. A year and a half ago we said we were going to start hiring CRNAs. We had more orthopedics. It just made sense to do it. It took six months to even get someone in for an interview. And this is Williamsburg. This is a nice place to live. So, my thought is if we had CAAs here, I would have options to hire other people, to bring in -- our cost has skyrocketed, the CRNAs because of the competition.

The competition that we have and I'm talking from an independent group, we do have the big management companies. They have deeper pockets than we do. Our cost for all our CRNAs and we have

employed 25, have gone up 30 percent in the past year just to maintain. And to be able to staff, our cost to do business has just skyrocketed because of staffing. But if we had a choice, if we had an option of another professional, I think that would -- it would certainly make my life a lot easier in hiring, and someone that is qualified to do the work alongside the CRNAs and under the care team model.

Thank you.

DR. PINEGAR: Once again, I'm Dr. Pinegar. I would just like to clarify a couple of points.

First and foremost, we have heard a fair bit about certain hospitals, perhaps hospitals that don't have access to a physician anesthesiologist, can't afford one, which, I think, is a little bit regrettable. I understand there are certain circumstances that might necessitate that.

But I would like to read just an excerpt from a statement from the American Study of Anesthesiologist in relation to medical supervision of nurse anesthetists by nonanesthesiologist positions, which states, general anesthesia, regional anesthesia, and monitored anesthesia care expose patients to risk. Nonanesthesiologist positions may not possess the expertise that

uniquely qualify and enables anesthesiologists to manage the most challenging medical situations that arise. While a few surgical training positions, such as oral surgery, provides some anesthesia specific education, no nonanesthesia programs prepare their graduates to provide an anesthesiologist level of medical supervision and clinical expertise.

However, surgeons and physicians certainly add to a patient's safety and quality of care by assuming medical responsibility for care when an anesthesiologist is not present. Anesthetist and surgical complications often arise unexpectantly and require immediately medical diagnoses and treatment.

Even a state law or regulation says the physician is not required to supervise non-physician anesthesia practitioners. The surgeon may be the only physician on site, whether the need is preoperative medical assessment, resuscitation from an unexpected complication, the surgeon may be called upon as the most highly trained professional present to provide medical direction of perioperative health care including nurse and anesthesia care.

To optimize patient safety, careful

consideration is required when a surgeon will be the only physician available as in some small hospitals, free standing surgery centers and surgeon's offices in the event of an emergency, lack of immediate support from other physicians trained in critical medical management may reduce the likelihood of successful resuscitation. This should be taken into account when deciding which procedures should be performed in settings without an anesthesiologist and which patients are appropriate candidates.

I think it's careful to consider that in certain critical access hospitals or small surgery centers that the types of cases that are being done are probably not to the level of what is being done in places like the Washington Hospital Center. So to draw a parallel between those two is probably inaccurate.

One other point I would like to speak on is a comment about the training difference between AAs and CRNAs. And I would like to reiterate that the requirements that are placed on students that rotate through us, whether they are Georgetown students, our Case Western AA students or even some of the ODU students that we had the pleasure of rotating through our hospital, that we require them to do

work beforehand, to be prepared for the cases they are going to participate in, to have done their homework on the patients they are going to take care of, and to have a perioperative anesthetist plan in place. This goes for both our student nurse anesthetists, our anesthesiologist assistant students as well as our resident physician, our resident anesthesiologist participants. We hold them all to the same level, the same standards of preparedness. And in my mind, they generally rise to that occassion as a whole regardless of the training philosophy they come from.

And the last point I would like to speak on is to the question that was asked of you, who would you want taking care of granny. And I have to say that being intimately involved in the training programs for both AAs, resident physicians and for anesthesiologist assistant students, that I echo and I agree with the statement that the American Society of Anesthesiologists has put out that anesthesia care team model is the best and, if possible, should be followed.

And if my grandmother, my wife, my children, if I need anesthesia support for a medical procedure having become very familiar with the

students that we graduated and subsequently hired both from the Georgetown program and from the Case Western program, I have no hesitation whatsoever in placing my life or the lives of my family in the care of the people that I have trained regardless of the training program they came from. I trust them implicitly. Many of the people here standing with me today representing our support for licensure for AAs are people that I trust with the lives of myself and with my family members. And I just wanted to make that point.

MR. WELLS: All right.

Is there anyone else here that would like to speak?

One more time, is there anyone else here that would like to speak?

Written comments will be accepted until 5 p.m. on July 31st, 2017. I appreciate everyone who is here. If you would like a copy of the transcript -- and this was complicated, so let's give her an applause -- please contact Ms. Jackson here at the office.

At this time I will conclude the public hearing concluded.

(Hearing concluded.)

CERTIFICATE OF COURT REPORTER

I, Anne Marie Nelson, hereby certify that I, having been duly sworn, was the Court Reporter in the County of Henrico, Virginia on June 27th, 2017, at the time of the hearing herein.

I further certify that the foregoing transcript is a true and accurate record of the testimony and other incidents of the hearing herein.

Given under my hand this 16th day of July, 2017.

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